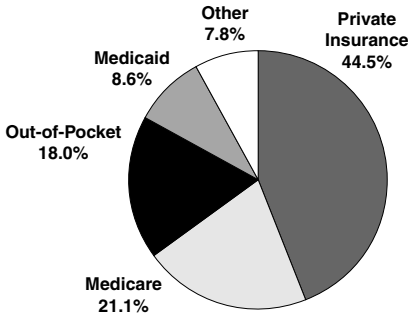
Healthpoint

Information from the Division of Health Care Finance and Policy

OUT-OF-POCKET SPENDING FOR HEALTH CARE SERVICES

Although insurance covers much of the cost of medical care in the United States, most insured individuals and families also pay out-of-pocket for some portion of their medical bills. Nationally, out-of-pocket spending accounts for almost one in every five dollars spent on health care, an amount nearly equal to national Medicare spending.[1] Despite the magnitude of consumer spending on health care, there is relatively little data about these expenses and how they are distributed across the population. While acknowledging that out-of-pocket expenses are certainly a greater burden for the uninsured, this issue of *Healthpoint* focuses on health care spending by the insured, policy concerns regarding these expenses, and the ways in which health care expenses are treated under tax law.

Health Care Expenses by Payment Source, 1996



Source: Agency for Healthcare Research and Quality

Understanding the Current Health Care Payment Climate

In an employer-based health insurance system, the portion of cost borne by employees in the form of out-of-pocket spending functions partly as a protection against "moral hazard," the tendency of the insured to use more health care services than they would if they paid the full cost of these services. Individuals who do not pay at the point of service for much of the cost of treatment tend to access care more often, at a lower level of need, or seek treatment that is more sophisticated or of a higher intensity than clinically indicated.[2] At the same time, there is little incentive for providers to compete on cost or be price sensitive in services such as inpatient care, for which insurance pays such a large part. In effect, payment by a third party weakens the incentive of both consumer and provider to be cost-conscious.

The growth of managed care has actually led to a decrease in the proportion of out-of-pocket costs paid by consumers for essential health services at a time when an aging population, the internet and direct to consumer advertising have increased health care spending overall. This is largely because managed care plans provide more comprehensive coverage of preventive care and prescription drugs, and employ less costly copay-

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ments rather than more costly coinsurance. At the same time, our concept of health insurance has evolved from financial protection against the cost of treating disease or accidental injury to the expectation of first dollar coverage.[3] A generation ago, middle class families budgeted for routine medical and dental spending, when health insurance was protection only from the expense of catastrophic illness and subsequent bankruptcy.

Policy Considerations

With Massachusetts employers facing a third year of substantial premium increases, some of which undoubtedly will be passed on to employees, one must ask how much an individual or family is capable of paying for health care and in what form are those charges easiest to absorb? At what level of contribution do individuals choose to access treatment too infrequently, too late, or forego a needed treatment or drug due to its cost? Employers and state health policy makers must consider whether out-of-pocket expenses fall equitably, if not equally, on all segments of the insured population, how best to use out-of-pocket fees to motivate patients to make cost-effective treatment choices, and what capacity employees have to pay out-of-pocket expenses.

How much of an insured individual's health care bill should be paid out-of-pocket relative to other sources of payment? This is a particularly salient question for Massachusetts, with its high managed care penetration rate, above national average use of teaching hospitals, higher than average per capita income, and employers who subsidize family health insurance premiums at a higher rate than the national average.[4]

Types of Employee Out-of-Pocket Expenses

Cost sharing of health expenses comes in several forms which differ in whom they affect, the ease in budgeting for them, their impact on seeking care, and their tax treatment. Insurance plans (whether managed or indemnity) and employers use some or all of the following forms of cost sharing to partially defray the cost of health services:

copayment—a specific dollar amount that doesn't vary with the cost of service. Copayments generally are set low enough not to deter appropriate care seeking, but may influence the site or type of care such as encouraging use of in-network providers or generic rather than brand name drugs.

reasonable and customary charge—the amount insurers assign to a health care service, often lower than what the provider actually charges.

balance billing—when providers bill patients the difference between their charge and the reasonable and customary amount paid by the insurer.

coinsurance—a percentage of the charge for health care services. When the reasonable and customary amount used by the insurer to calculate its share of the bill is lower than what the provider charges, patients effectively pay a higher coinsurance rate than the one stated (typically 20%) in their insurance policy.

deductible—a specific amount, usually $100-$1000 per family member, paid each year before insurance will cover services. Patients effectively pay more than the specified deductible when the

insurer tallies deductibles using the assigned reasonable and customary rate rather than the provider's charge. Insurers also may calculate physical and mental health service deductibles separately.

interior cap—the maximum amount covered by insurance per service or incident. Patients pay 100% of the amount exceeding the cap.

payment for services not covered by insurance—patients pay 100% of the charge for services not covered. Such services range from cosmetic to experimental procedures, alternative therapies, politically controversial services such as abortion, and those not considered medically necessary such as sterilization reversal, circumcision and, until mandated, breast reconstruction after mastectomy.

payment for covered services that a consumer chooses to pay out-of-pocket—usually for confidentiality or because a chosen provider does not participate in a particular plan, these services range from HIV and genetic testing to mental health services, as well as gynecological services sought by insured teenagers who prefer to pay out-of-pocket rather than involve their parents.

Another form of cost sharing, though not considered an out-of-pocket expense, is the employee contribution to the premium. While the amount of the employee contribution certainly affects the company's take-up rate (the percent of employees who accept offered insurance), it is not paid at the point of service and is not intended to affect the actual use of health care services. Employees may consider premium cost when they decide whether to accept insurance, however, in two surveys of Massachusetts residents, fewer than 30% of respondents who access health insurance through their employer, could recollect their monthly or yearly dollar contribution to the premium.[5]

Tax Treatment of Health Expenses—An Uneven Playing Field

The federal government, through its tax code, either attenuates or exacerbates the bite of health care expenses to employers and individuals. By making the employer portion of the premium cost tax deductible, the federal government foregoes revenue on presumably what would otherwise be a portion of the employee's income. This encourages rich benefit packages and penalizes those who obtain health insurance in the individual or non-group market since those premiums are not fully tax deductible in most cases. The employee share of the premium is consistently deducted from each paycheck, making this amount free from temptation, easier to budget and, therefore, among the forms of cost-sharing more easily absorbed. Employee premium contributions are increasingly deducted on a pre-tax basis, allowing those who earn enough to pay the required amount to lower their reportable gross taxable income.

Since 1978, the federal government also has allowed a pre-tax mechanism to pay for anticipated out-of-pocket medical and related expenses. Under the rules of these flexible spending accounts (FSAs), at the outset of a year, employees predict the amount they expect to pay out-of-pocket in uncovered or cost sharing expenses. The employer then deducts money on a pre-tax basis from each paycheck to cover those expenses, and upon submission of proof that the expense was incurred, reimburses the employee that amount from his account. The risk to the employee is that any unspent money is forfeited at the end of the year, so employees tend to estimate their expenses conservatively. However, these accounts do serve those in higher than average income groups by cushioning the impact of out-of-pocket expenses, especially those planned, but sometimes less medically neces-

sary services such as LASIK eye surgery, cosmetic surgery and orthodontia. While there is no statutory limit on the amount allowed in an FSA, most employers limit set asides to $2000-$3000 yearly.

Related to and often confused with FSAs, Archer medical savings accounts (MSAs) are currently available, but only to small businesses and the self-employed. To be eligible, one must have a high deductible insurance plan which also caps total allowable out-of-pocket expenses. One sets up a tax deferred savings account to pay for health care and health insurance expenses and is allowed to accumulate savings to pay for future medical expenses. One need not accurately estimate yearly out-of-pocket expenses nor forfeit unclaimed monies at the end of the year, however, the allowable contribution to the MSA depends on the size of the deductible.

For those with extraordinary out-of-pocket medical expenses, the federal government allows itemized deductions once those expenses exceed 7.5% of adjusted gross income, provided that they were not paid through an FSA nor an MSA. Only about 4% of the population in Massachusetts and nationally takes advantage of this deduction in a given year.[6] Those who utilize the deduction tend to be in the middle to low income brackets since those with higher income are usually better insured and would need to spend quite a bit more out-of-pocket to exceed 7.5% of their income.

The next issue of Healthpoint will discuss health care services not typically covered by insurance, population groups who use such services disproportionately, and utilization trends for uncovered services showing that more consumers are paying out-of-pocket for the elective services they desire.

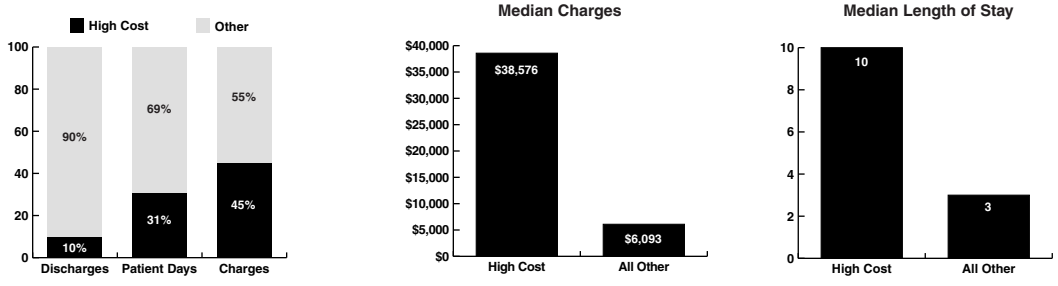
Endnotes

1. AHRQ Medical Expenditure Panel Survey, "Distribution of Health Care Expenditures, 1996," *Highlights*, May 2000 (Pub. No. 00-0024).
2. Robert Brook et al., "The Effect of Coinsurance on the Health of Adults: Results from the Rand Health Insurance Experiment" (under a grant from the US Department of Health and Human Services), December 1984, p. 26.
3. Fred Silverman (Producer/Director/Writer) and Howard Sharp (Editor/Co-Writer), "HealthCare Crisis: Who's at Risk?" PBS Broadcast. See www.pbs.org/healthcarecrisis/history.htm
4. Kaiser Family Foundation, State Health Facts Online: profiles on all 50 states. See www.statehealthfacts.kff.org/
5. Massachusetts Division of Health Care Finance and Policy, Health Insurance Survey of Massachusetts Residents, 1998 and 2000.
6. Internal Revenue Service Data Book 2000, Publication 55B. See www.irs.gov/tax_stats/soi/other_ia.html

Did you know?

High Cost Patients Use More Hospital Resources

Inpatient stays with charges of $25,000 or more accounted for only 10% of discharges but 31% of patient days and 45% of charges in Massachusetts hospitals in FY00. After hospital discharge, 53% of these high cost patients needed non-acute care compared to just 27% of lower cost patients. Seven percent of high cost patients died in the hospital compared to just 2% of all other patients. The top three diagnoses for high cost discharges were major joint and limb procedures of the lower extremities, psychoses, and respiratory system diagnosis with ventilator support. Interestingly, psychoses was also one of the three most common diagnoses among lower cost discharges. The other two were birth related.



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